STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. BUILDING _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ELMS	**7449 FAIR OAKS DRIVE CLEMMONS, NC 27012**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/21/23-8/25/23. The facility was found in compliance with the requirement (CFR 483.73, Emergency Preparedness. Event ID #EED011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 8/21/23-8/25/23. Survey team returned to the facility on 08/28/23 to obtain additional information and exited on 8/30/23. Therefore, the exit date was changed to 8/30/23. The following intakes were investigated NC00200847, NC00191819, NC002068032, NC00194584 and NC00205206. 17 of the 17 complaint allegations did not result in a deficiency.	F 000		
F 609 SS=B	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		9/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/18/2023

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff and local Department of Social Services (DSS) Adult Protective Services (APS) Supervisor interviews, the facility failed to report an allegation of resident abuse to Adult Protective Services within the required time frame for 1 of 1 resident abuse allegation reviewed (Resident #2). Findings included: Review of the policy titled Abuse investigation and reporting for Senior Services dated 4/19/06 and revised 1/26/23. Which stated: "The administrator (or designee) will ensure that a completed DHSR form initial Allegation Report located at: NC DHSR CHCPIS: Provider Information fncdhhs.gov) is submitted to the Health Care Personnel Registry Section of the Division of Health Services Regulations within 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury (see #1). All other allegations will be reported using the same form within 24 hours. Even though the form asked for employee	F 609	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Plan of Correction – F609 (B) Reporting Alleged Violations 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Report for Resident #2 was sent to	

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F 609	Continued From page 2 information, it can and should be utilized for any individual against whom an allegation is made. Adult Protective Services must also be notified within the same frames." Resident #2 was admitted to the facility on 8/31/17 with diagnoses that included in part, Alzheimer's Disease. The quarterly Minimum Data Set (MDS) assessment dated 6/6/23 revealed Resident #2 was severely cognitively impaired and had no negative behaviors. The Initial Allegation Report dated 7/31/23 revealed an allegation of resident to resident abuse for Resident #2 who was observed by staff with a male resident (Resident #283) in her room with his head on her bare chest. The report was faxed to Health Care Personnel Investigations (HCPI) of the Division of Health Services Regulations (DHSR) on 7/31/23 at 10:36 PM. Review of section I "Notification to Other Agencies- Department of Social Services" revealed it was left blank. The Investigation Report (5day) was faxed to the HCPI Section of the Division of Health Services Regulations (DHSR) on 8/7/23 3:34 PM. Review of section I "Notification to Other Agencies-Department of Social Services" indicated APS was notified on 8/7/23. An interview conducted on 8/29/23 at 5:05 PM the Administrator revealed she had a prior agreement with their county DSS/APS to send them the report after the 5- day investigation was completed.	F 609	NCNAR within time parameters for Initial and Investigation reports. Additionally, it was sent to APS (Adult Protective Services) with the initial 2/24 hour and 5 day investigation combined with the determination of the outcome of the investigation per local APS direction. NHA was educated on 9-1-23 regarding Regulation and LSC policy to report to APS in 2/24 hour timeframe for initial report. NHA and COO expressed the intent/commitment to comply with this via video with DHSR on 9-1-23. Any and all future reports will be sent to APS individually at the 2/24 hour mark for the initial and at the 5 day for the investigation completion, regardless of any local county preferences. 2. How you will identify other residents having the potential to be affected by the same deficient practice. NHA was instructed via email by COO on 9-1-23, along with other NHAs in the company of this Regulation/policy and has full intent and commitment to comply with the regulation/policy. Leadership staff in the facility were also educated by NHA on 9-1-23 to send the 2/24 hour report and 5 day report to APS in addition to NCNAR within the same timeframes. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Fax cover sheet was prepared and copies made to send to APS with any Initial 2/24 hour reports and placed with reporting	

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F 609	Continued From page 3 An interview conducted on 8/31/23 at 11:19 AM the DSS Adult Protective Services Supervisor revealed that nursing homes were required to follow guidance from DHSR for reporting.	F 609	materials. Instructions were placed with the APS cover sheets so that it would be clear to send reports in same timeframe as to NCNAR. An audit tool/checklist was created by NHA and will be used to track that reports are sent to APS as well as NCNAR and will be monitored by the IDT. All staff were educated via message regarding the reporting timeframes for NCNAR and APS by NHA on 9-13-23. 4. How the corrective actions will be monitored to make sure solutions are sustained. Quality Assurance Performance Improvement plan has been put in place for Monitoring Reporting by NHA on 9-1-23. NHA will report results to QAPI committee quarterly for one year.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 7.69% (2 errors out of 26 opportunities) for Resident #60. The findings included: 1a. A medication administration for Resident #60	F 759	Plan of Correction – F759 (D) Free of Med Error Rts 5 Prcnt or More 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. For Resident #60, Physician services was notified at time of error verbally and order	9/18/23

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F 759	Continued From page 4 was observed on 8/23/23 at 10:47 AM, Medication Aide (Med Aide) #4 administered a Metoprolol Succinate ER 12.5 mg tablet, for Atrial Fibrillation (irregular heartbeat) after crushing it with other medications and mixing it in applesauce. Review of physician orders for Resident #60 revealed an order dated 8/12/22 at 2:49 pm for Metoprolol Succinate ER Tablet Extended Release. Give 0.5 tablet of 25 mg tablet by mouth once a day for Atrial Fibrillation (an irregular heartbeat). Review of the August 2023 Medication Administration Record for Resident #60 revealed no orders for crushed medications, and the Metoprolol Succinate Extended Release 24 Hour tablet, half of a 25 mg tablet (12.5 mg) by mouth was administered August 1 through August 23, 2023. Review of the Progress Notes revealed Nurse #5 documented crushing medications for Resident #60 due to difficulty swallowing on 6/25/23 at 9:57 am, on 7/2/23 at 12:21 pm, and on 8/7/23 at 11:58 pm. Review of the 7/27/23 at 1:34 pm Social Services Progress Note revealed Social Worker #1 documented Resident #60 had slurred speech related to Dysphagia, Pharyngoesophageal phase, and could make her needs known and be understood. The monthly Pharmacy Consultant #1's Progress Note on 8/9/23 at 11:38 am revealed that medication changes were reviewed, and that the status of Resident #60 was being monitored.	F 759	was obtained to change medication to crushable format (Metoprolol Tartrate oral tablet 6.25mg by mouth bid) and to obtain vital signs q shift for one week to monitor medication change. The Pharmacy consultant was notified and she advised that there would be no adverse reactions anticipated from error. Resident #60 continued to have regular BMs and vital signs. No adverse reactions were noted after Physician review of documentation. 2. How you will identify other residents having the potential to be affected by the same deficient practice. DON obtained a list of all residents on Metoprolol Succinate ER tablets and consulted with Physician to determine if any changes were needed. There were four other residents on this medication that physician services changed to Metoprolol Tartrate on 8-24/25-23. Obtained a list of all current residents that have medications crushed and added that information to the special instructions section in the chart so it would be easy to find. Pharmacist reviewed the list of those with crush meds on 9-13-23 to see if any other recommendations were needed and any recommendations were sent to Physician. Obtained a list of all residents on Polyethylene Glycol. Consulted with Pharmacist to see if any changes were needed and to be consistent, updated all orders for this medication to be given with 4-8oz water per manufacturer instructions, pharmacist recommendation and Physician order approval.	

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F 759	Continued From page 5 There were no recommendations. The previous month's documentation by Pharmacy Consultant #1 on 7/9/23 at 12:04 pm also revealed the medication changes were reviewed and that the status of Resident #60 was being monitored. There were no recommendations. An interview on 8/23/23 at 3:41 pm with Pharmacy Consultant #1 revealed that Metoprolol Succinate extended release could be cut in half from a 25 mg tablet but should not be crushed because it was intended to be administered once a day and would slowly release throughout the day once swallowed. She continued that the dose of 12.5 mg was a small dose and would not cause harm if crushed. An interview on 8/23/23 at 4:40 pm with Nurse #6 revealed she recalled that Resident #60 started to receive crushed medications the previous month because Resident #60 occasionally choked on her medications and had vomited them up on one occasion. She further revealed Resident #60 would have been able to take the 12.5 mg Metoprolol Succinate tablet without crushing it because it was small enough that she wouldn't have choked on it. On 8/23/23 at 9:00 pm, a new order was in the electronic medical record for Resident #60 for Metoprolol Tartrate Oral Tablet, 6.25 mg by mouth two times a day for Atrial Fibrillation. An interview with the Director of Nursing (DON) on 8/25/23 at 10:22 am revealed that Resident #60 had a decline in June 2023, began to receive crushed medications, and the nurses and med aides were informed about crushing Resident #60's medications through communication at the	F 759	3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will not recur; Med Error report was completed and signed by Physician. An in-service education was conducted for Med Aide #4. Med Aide #4 was assigned seven additional days of orientation. Pharmacist returned to do a med pass audit with Med Aide #4 and had 0% Med error rate on 9-13-23. All Medication Aides and Nurses were educated via message by NHA on 9-12-23regarding crushed meds and observation of ingestion of medications. A Medication Administration observation audit tool was obtained and will be used by administrative nurses to conduct audits with random Med Aides unannounced three times/wk. for 2 weeks; 1x/wk. for 1 month; 2x/month for remainder of 1 quarter; then will re-evaluate in PIP team if further audits are needed. 4. How the corrective actions will be monitored to make sure solutions are sustained. A Quality Assurance Performance Improvement Plan has been put into place by Director of Nursing on 9-1-23. DON will report results of these audits and corrections made monthly to Performance Improvement team, which will report results quarterly to the QAPI committee.	

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F 759	Continued From page 6	F 759		

change of shift reports. The DON continued that there were standing orders from their parent company for crushing medications, and that a standing order for crushing medications was an order that could be implemented, unless contraindicated by the drug manufacturer, and the nurses and med aides would know a standing order had been implemented by documentation in the Progress Notes. She continued that crushing medications could also be temporary, and that Resident #60 had no orders from a physician for crushing medications because a standing order was an order. She revealed that the extended-release Metoprolol Succinate ER tablet should not have been crushed, and that a new order for Metoprolol Tartrate was being added for Resident #6.

An interview on 8/25/23 at 11:00 am, Med Aide #4 stated she gave Resident #60 crushed medications because Resident #60 liked them to be crushed. Med Aide #4 recalled that the medication card for Resident #60 from Pharmacy for Metoprolol Succinate had "do not crush" written on it and crushed it anyway because of discussions at change of shift reports that Resident #60 preferred her medications crushed. She continued that she could not write in the Progress Notes but read in the Progress Notes about crushing medications for Resident #60. She concluded that she confused Metoprolol Succinate (a non-crushable medication) with Metoprolol Tartrate (a crushable medication).

1b. During the medication administration observed to Resident #60 on 8/23/23 at 10:47 AM, Med Aide #4 administered one capful of polyethylene glycol 3350 powder solution sugar free mixed in a medication plastic cup with water.

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Med Aide #4 set the medication cup of polyethylene glycol in front of Resident #60 on her bed table. Resident #60 began to sip the liquid polyethylene glycol and Med Aide #4 left the room.

Review of physician orders for Resident #60 revealed an order dated 9/8/22 at 7:00 am for polyethylene glycol 3350. Give one scoop by mouth one time a day for Constipation.

Review of the August 2023 Medication Administration Record for Resident #60 revealed polyethylene glycol 3350, one scoop by mouth one time a day for constipation was administered August 1 through August 23, 2023.

An interview on 8/23/23 at 11:21 am with Nurse #6 revealed when she passed medications, she stayed with Resident #60 until she completed her polyethylene glycol mixed with water.

On 8/23/23 at 4:34 pm, the medication plastic cup with liquid polyethylene glycol was observed undrunk and sitting in front of Resident #60 on her bed table.

An interview with the DON on 8/25/23 at 10:22 am revealed there would be extra training for Med Aide #4, and the nurses would also complete closer oversight of the Med Aides to ensure correct medication pass protocols were followed.

An interview on 8/25/23 at 11:11 am with Med Aide #4 revealed that she left the cup of polyethylene glycol mixed in water on the bedside table of Resident #60.